Section IV
Massachusetts Maternal, Infant, and Early Childhood Home Visiting Capacity

Home visiting programs have grown consistently over the past decade and Massachusetts has kept pace with this national trend. Home visiting programs are adaptable, allowing for multiple types of interventions and variation with respect to their focus, target participants, service area, program activities and service provider[1]. Although variation in program design and delivery is crucial, home visiting programs share some common components.

Definition of Home Visiting Program: Massachusetts

Massachusetts home visiting programs offer voluntary services to individuals predominately in a home setting, although many offer group services as well. Services are delivered from trained home visiting professionals or paraprofessionals with the goal of addressing specific issues based upon the individual's eligibility for the program[2]. Home visits are structured to ensure consistency that allows for evaluations to link program components with intended outcomes. For the purposes of this needs assessment, the following overview of Massachusetts home visiting programs includes those programs with the characteristics described above, as well as those delivering services as part of federal IDEA Part C requirements. Programs are excluded if they provide one-time home visits, do not provide routine and sustained home visits or those who are bound to Child Protective Services or court-mandated referrals, as family participation in those services are not voluntary[3].

The discussion below summarizes the home visiting programs in Massachusetts using the data compiled from the Home Visiting Program Survey. Each home visiting program is described in detail. To the extent possible, program descriptions include the home visiting model or approach, the program service components, program goals, number and type of individuals and families served, demographic characteristics (when available), geographical area served, and the individual programs' gaps, concerns, and ability to meet the needs of their eligible populations. This discussion also includes a capacity map that highlights the number of home visiting programs within the top 18 high-risk communities in Massachusetts.

Overview and Capacity Map of Massachusetts Home Visiting Programs

This section provides an assessment of the home visiting programs' ability to meet the needs of at-risk maternal, infant, and early childhood populations and examines the statewide gaps in maternal and early childhood home visiting programs. Massachusetts' currently has a wide variety of community-based and statewide initiatives and programs:

- 14 home visiting programs
- 5 national home visiting models
- 5 national evidence-based home visiting programs
- 3 program that provides services to one specific community (2 in Boston & 1 Springfield)
- 3 programs that provide services statewide (on an as needed basis)

Annually these programs:

- Serve approximately 47,592 families, with the median number of 669 families per program (min = 20 ; max = 33,346)
- Median cost of $2,750 per family (min = $781 ; max = $10,000)

Figure IV.1

Program Name	Number of Families Served	Programmatic Cost per Family
Boston Healthy Start Initiative	1,792	$781
Boston Home Visiting Collaborative	38	Unknown
Early Connections	83	$1,300
Early Head Start	358	$10,000
Early Intervention	33,346	$3,000
Early Intervention Partnership Program	669	$1,397
F.O.R.Families	3,196	Unknown
Good Start	338	$1,700
Healthy Baby Healthy Child	1,414	$2,829
Healthy Families Massachusetts	3,131	$3,300
Parent Child Home Program	1,500	$2,750
Parenting Works	20	Unknown
Parents as Teachers	279	Unknown
Visiting Moms	190	Unknown
Young Parents Support Program	1,122	Unknown
TOTAL/ AVERAGE COST	**Total Families: 47, 592**	**Average Cost: $3,006**
MEDIAN	**Median: 669**	**Median: $2,750**

Boston Healthy Start Initiative

The Boston Healthy Start Initiative (BHSI), based on the national evidence-based Healthy Start Initiative model, is a comprehensive home visiting program that aims to decrease the racial and ethnic disparities in perinatal health outcomes, such as infant mortality, and to promote healthy supportive parent-child relationships. BHSI is a federally funded voluntary program that provides community-based home visiting and support group services to Black pregnant women and their children up to the child's second year of birth who reside in Boston. BHSI core case management and home visiting services focus on health education, including prenatal care, nutrition, and inter-conceptional care. BHSI services also address housing, mental health, substance abuse, financial literacy, and domestic violence issues. Service delivery consists of routine health assessments, on-going family health education, socio-emotional assessments, support groups, and referrals as needed.

As of May 2009, BSHI delivered services to 1,792 Black pregnant/postpartum women at a cost of $781 per family. There is no waitlist for BSHI, yet some clients are lost after delivery and program administrators also note difficulty in providing adequate mental health services and referrals to specific populations, particularly Latinos, Somalians, and Haitians. This difficulty is attributed to the lack of mental health professionals that are culturally diverse and who speak the language of these populations.

Figure IV.2

Boston Health Start Initiative Program Characteristics	
National Evidence-Based Model	Yes
National Model	Yes
Communities Served (bold denotes communities that are among the top 18 most at risk)	**Boston** (including the neighborhoods of: Roxbury, Dorchester, Mattapan, Hyde Park, South End, and Jamaica Plain)
Client Demographics	
Race	100% self-identified Black
Educational attainment	86% identify highest attainment as 'high school'
Federal or other assistance	90% on public assistance

Boston Home Visiting Collaborative

The Boston Home Visiting Collaborative (BHVC), based at the Visiting Nurses Association of Greater Boston, serves mothers with children through age 5 years who are at-risk or experiencing maternal depression in the Allston/Brighton neighborhoods of Boston. The Early Childhood System of Care home visitor, a Masters-level clinician, partners with local community-based home visiting programs to provide at-home therapy for participating mothers who are at-risk or experiencing maternal depression. Using the In-Home Cognitive Behavioral Therapy (CBT) model, the BHVC program aligns its services with the curriculum of the concurrent home visiting program to provide 15 therapeutic visits. The program also provides additional services, such as mental health trainings, to home visiting programs to help enhance the capacity of the existing community organizations to provide services and improve the overall care for families in need of social-emotional support.

Since March 2010, the program has served 38 mothers, with 100% of its funding coming from the United Way. While the program itself does not have a waitlist, as a pilot program, it is limited to the Allston and Brighton neighborhoods. To address this issue of limited capacity, the program plans to expand into different neighborhoods of Boston in the fall of 2010.

Figure IV.3

Boston Home Visiting Collaborative Characteristics	
National Evidence-Based Model	No
National Model	No
Communities Served (bold denotes communities that are among the top 35 most at risk)	**Allston and Brighton** (neighborhoods of **Boston**)
Client Demographics	
Data is unavailable	

Early Connections

The Early Connections program, run by the Jewish Family and Children's Service (JFCS), is a home visiting program for mothers who live within the service delivery area (see table below) and who are facing issues related to postpartum emotional health and/or their relationship with their baby. Through the use of masters and doctoral-level clinicians who have special training in infant/parent mental health, the Early Connections program address developmental outcomes for infants and children by improving maternal mental health and enhancing the mother's capacity for emotional availability and empathetic care. Early Connections service model is based upon the Parent-Child Psychotherapy (CPP), a National Child Traumatic Stress Network (NCTSN)-approved evidence-based practice. Service components of the CPP include family assessments, maternal depression screens, parent-child psychotherapy, dyadic attachment assessments, support group services, and additional information and referrals as needed.

In FY09, the program served 83 mothers at a cost of approximately $1,300 per family. There is a $100 fee per visit, but reduced and free care is available if families are not able to afford the fee. While the Early Connections program does not have a waitlist, the capacity of the program to meet the perceived needs of the surrounding communities is limited. Administrators note two major issues. The first is workforce capacity, as there are not enough clinicians with specialized training to expand services. The program is limited to only those communities where clinical home visitors reside or are able to visit easily. The second issue reflects the financial limitations of a clinical home-visiting model, as clinical home visiting is expensive and is not reimbursable by most insurance companies.

Figure IV.4

Early Connections Collaborative Characteristics		
National Evidence-Based Model	No	
National Model	No	
Communities Served (bold denotes communities that are among the top 18 most at risk)	Metro Boston (26 communities), concentrated in **Boston**, Cambridge, Somerville**,** & Waltham	
Client Demographics		
Race		
38.2% Caucasian	35.3% Latina	8.8% African American
8.8% Asian	8.8% Arab/North African	
Income Level		
50% less than 25K	20.6% 50-75K	11.8% 75-100K
11.8% 100K+	5.9% 25-50K	
Education Level		
61.8% College or Post College	17.6% Some College	11.8% Less than High School
8.8% High School		
Age		
32.4% age over 35	32.4% age 30-35	14.7% age 20-25
11.8% age 25-30	8.8% under 20	

Early Head Start

Early Head Start (EHS) is a national evidence-based multi-service early childhood program which provides home visiting to income eligible families, many of whom have multiple risk factors and live in identified at-risk communities. The eligible populations for Early Head Start are children ages birth to three and pregnant women of any age. EHS is run by the Office of Head Start (OHS), Administration for Children and Families (ACF) within the U.S. Department of Health and Human Services (DHHS). The goal of EHS' home visiting component is to promote school readiness and enhance children's physical, dental, nutritional, social/emotional, and cognitive development. Early Head Start also promotes healthy family functioning, including healthy outcomes for pregnant women and economic self sufficiency. Primarily through the use of paraprofessional home visitors, EHS' home visiting component provides a number of comprehensive services, such as developmental screening, hearing and vision screening, linkages with medical and dental homes, on-going assessments, family support services, and referrals as needed.

In FY09, the 10 Early Head Start home visiting program sites served 242 children and 116 pregnant women statewide. The estimated cost of the Early Head Start home visiting program is approximately $10,000 - $11,000 per child (this estimate includes both the home visiting and the center-based components). Limitations of the Early Head Start program, administrators note, include the lack of resources to meet the needs of eligible families. While the waitlist for the EHS home visiting component is unknown, the cumulative waitlist for both the Early Head Start and Head Start programs in the spring of 2010 was an estimated 4,000 families statewide. Finally, administrators also feel that demand exceeds enrollment capacity for Early Head Start and similar programs, and that more resources need to be dedicated to programs serving at-risk populations.

Figure IV.5

Early Head Start Characteristics		
National Evidence-Based Model	Yes	
National Model	Yes	
Communities Served (bold denotes communities that are among the top 18 most at risk)	Amherst, Arlington, Attleboro, Belchertown, Berkley, Billerica, **Boston**, Braintree, Brookline, Carlisle, Chelmsford, Chicopee, Cummington, Dighton, Dracut, Dunstable, Dudley, Easthampton, Enfield, **Fall River**, Freetown, Goshen, Granby, Greenwich, Greenfield, Hadley, Hatfield, Haverhill, Holbrook, **Holyoke**, Hull, Huntington, Lakeville, **Lowell**, **Lynn**, Lynnfield, Marblehead, Middleboro, Middlefield, Millbury, Milton, Nahant, Newton, Norton, Orange, Oxford, Pelham, Plainfield, Prescott, Quincy, Randolph, Raynham, Rehoboth, Saugus, Seekonk, Somerset, Somerville, South Hadley, Southampton, **Southbridge**, Spencer, **Springfield,** Swampscott, Taunton, Tewksbury, Tyngsborough, Waltham, Ware, Watertown, Webster**,** Westford, Weymouth, Williamsburg, Wilmington and Worthington	
Client Demographics		
Race		

44.5%Hispanic / Latino	27.5% White	25.3% Black/African American
16.6% Unknown	12% Multi-racial	8.7% Other
5% American-Indian/ Alaskan	4.9% Asian	.07% Native Hawaiian or Pac. Islander
Marriage Type		
30.8% Two parent families	69.3% Single parent families	
Language		
50% Families spoke a language other than English as their primary language		
Federal or Other Assistance		
38.6% Families receiving TANF	13.7% Families receiving SSI	
Children with Health Insurance		
99.60% Children with Health Insurance (at End of Enrollment Year)		
95.1% Public	4.9% Private	0.40 % None
Top 5 Family Services		
67.2% Parenting Education	60.7% Health Education	42% Emergency/Crisis Intervention
29.5% Housing Assistance	16.2% Mental Health Services	

Early Intervention (EI)

The Massachusetts Early Intervention program (EI) is a family-centered early childhood home visiting program run by the Massachusetts Department of Public Health (MDPH). Funded through a combination of state, federal, and third party reimbursement funds, EI serves children up to age 3 who either have 1) a diagnosed medical or disabling condition, 2) a 30% delay in specific development areas, or 3) who are at-risk for delay and their families. EI assesses and assists children and families through an array of services to facilitate the development process as well as to help children acquire the skills they need to succeed. EI service components include on-going developmental screens, routine family socio-emotional assessments, child-centered development activities, group-based services, child group services, and referrals as needed.

EI provides services through multi-disciplinary teams. The team, depending upon the needs of the child, may include a developmental specialist, physical therapist, speech-language pathologist, psychologist, occupational therapist, social worker, nurse, and/or other specialty service providers. In FY09, EI served 33,346 children and their families statewide, and the cost of service was approximately $3,000 per family. Because EI is a statewide program, it does not have a waitlist. However, fiscal and workforce capacity issues have presented a challenge in meeting the needs of eligible families. Additionally, EI has had to restrict eligibility requirements in recent years due to fiscal limitations and cutbacks. Finally, EI administrators have noted difficulties in hiring appropriate therapists and specialty service providers due to a lack of qualified applicants.

Figure IV.6

Early Intervention Characteristics		
National Evidence-Based Model	No	
National Model	No	
Communities Served (bold denotes communities that are among the top 18 most at risk)	**Statewide as needed**	
Communities Served (bold denotes communities that are among the top 18 most at risk)	**Statewide as needed**	
Client Demographics		
Race		
63% White	17.9% Hispanic / Latino	8.8% Black
3.8% Other/Unknown/Missing	0.2% American-Indian	
Income Level		
25% less than 200% FPL	11% 200-300% FPL	10% 401-550% FPL
9% 301-300% FPL	7% greater than 551-775% FPL	
Children with Health Insurance		
52% Third Party Insurance	45% Public (Medicaid)	1% None

Early Intervention Partnership Program (EIPP)

The Early Intervention Partnership Program (EIPP) is a perinatal home visiting program run by MDPH and funded through a combination of third party coverage and the federal Maternal and Child Health (MCH) block grant. EIPP reaches out to high-risk pregnant and postpartum women and their infants up until the age of one and seeks to reduce infant and maternal mortality and morbidity, build healthy dyadic relationships, and promote overall optimal health and wellness for women and their infants along the life course. Eligibility for EIPP includes a number of risk factors, such as young maternal age with two or more children, previous high risk birth, inadequate prenatal care, homelessness, domestic violence, substance abuse, and others. The program provides home visiting and group-based services to pregnant and post partum women, including maternal and newborn screenings, assessments and services, and referrals to address the physical, emotional, and environmental health needs of women and their infants.

In FY09, EIPP served 669 women and their infants through the use of an MCH home visiting team. The MCH team is comprised of nurses, social workers, and community heath workers. It costs approximately $1,397 per family. EIPP does not have a waitlist but program administrators expressed concerns over the program's limited geographic reach. Due to fiscal constraints, EIPP is only able to operate in 8 communities statewide and is unable to meet the perinatal needs of other high-risk communities.

Figure IV.7

Early Intervention Parenting Program Characteristics	
National Evidence-Based Model	No

National Model	No	
Communities Served (bold denotes communities that are among the top 18 most at risk)	Cambridge/Somerville, **Fall River**, Leominster/**Fitchburg**, **Lowell, Lynn, New Bedford, Southbridge**, and **Springfield**	
Client Demographics		
Race		
45.1% White	41% Hispanic	26% Other
12.5% Black	7.7% Asian	3.2% Missing
2.9% Unknown	2% Multi-racial	0.5%American Indian/Native Alaskan
0.2% Native Hawaiian/ Pacific Islander		
Marriage Type		
68.2% Single	25.6% Married	2.5%Seperated
2.2% Missing	1.4% Divorced	0.2% Widowed
Health Insurance		
64.7% MassHealth	20.8% Healthy Start/MassHealth Limited	13.1% Other
9.3% Private	3.4% Missing	1.1% None
0.9% Health Safety Net Fund (free care)		

F.O.R. Families

The F.O.R. (Follow-up, Outreach, and Referral) Families program, administered by MDPH, is a home visiting program for homeless families receiving Emergency Assistance shelter benefits from the Department of Housing and Community Development (DHCD). F.O.R. Families receives full funding and referrals from DHCD. The program assists families with the transition from homelessness (families residing in hotels) to permanent stable housing, through case management and routine family assessments, on-going family support and education, and referral services. F.O.R. Families home visitors are nurses, social workers, or community service workers.

In FY09, F.O.R. Families served 3,196 families statewide. While the program does not have a waitlist, program staff note several program limitations. The first is that the program is only able to serve families who are eligible for Emergency Assistance, thus limiting the program's scope of service. Home visitors are only able to work with families while they are residing in hotels, and services end once a family is placed into permanent housing. Continuity of care, in particular, suffers as families struggle to find support systems during this vulnerable transition period.

Figure IV.8

F.O.R. Families Characteristics	
National Evidence-Based Model	No
National Model	No
Communities Served (bold denotes communities that	**Statewide** in communities housing homeless

are among the top 18 most at risk)	families in hotels	
Client Demographics		
Race		
37% Hispanic / Latino	28.1% Black/Non-Hispanic	27%White
6.53% Other/ Non-Hispanic	0.9% Asian/Pacific Islander	0.5% Native American
Age		
28.05% under age 24	24.4% age 24-28	17.7% age 39+
16.15% age 29-33	13.7% age 34-38	
Head of household		
92% female head of household	8% male head of household	
Number of Children		
49.28% had 1 child	27.3% had 2 children	19.43% had 3+ children
4% were pregnant		

Good Start/Connecting Families Social Services

The Good Start/Connecting Families Social Services program is a home visiting program focused on parent support. The program is run by the Massachusetts Society for the Prevention of Cruelty to Children (MSPCC) and is funded through various private and public sources. Good Start serves pregnant women or parenting families with children up to the age of 16 who face challenges that could potentially put the child and/or family at risk. The focus of the program is on quality parent child interaction, child development, age appropriate activities, nurturing, and effective discipline. Through a validated curriculum, the program provides home-based and group-based parenting education services to help build relationships that reinforce positive parenting skills and beliefs. Good Start also provides linkages to community connections and programs as needed.

Staffed by Bachelors-level trained home visitors, the Good Start program served 338 families across its multiple sites in FY10. The program costs approximately $1,700 per family and has a waitlist of 71 families. Good Start program administrators point to an overwhelming need for more funding to 1) decrease waitlists, 2) increase capacity to reach vulnerable families, particularly undocumented families who are difficult to link to other resources because of their immigration status, and 3) enhance program capacity to provide transportation and supplies for group services.

Figure IV.9

Good Start Program Characteristics	
National Evidence-Based Model	No
National Model	No
Communities Served (bold denotes communities that are among the top 18 most at risk)	Cape Cod & Islands, **Greater Boston, Greater Holyoke, Greater Lawrence, Greater Springfield, and Greater Worcester**
Client Demographics	
Data is unavailable	

Healthy Baby Healthy Child (HBHC)

The Healthy Baby Healthy Child (HBHC) program is a perinatal home visiting program administered by the Boston Public Health Commission (BPHC). HBHC is funded primarily by municipal grants and receives a small amount of federal funding from HRSA. HBHC serves pregnant and postpartum women of any age and parenting families with children through the age of 5 years who reside in Boston. The program is designed to promote infant survival, positive birth outcomes and child development, and family unity by connecting parents and infants (from pregnancy through 5 years) to services to prevent or reduce poor health and/or developmental outcomes. Service components include on-going health and emotional family assessments, maternal depression screens, child health assessment, oral screenings, connections to additional community resources, and referrals as needed.

In FY 09, HBHC's home visitors – who are comprised of public health nurses, social workers, public health advocates, and early childhood educators – served 1,414 families at a cost of approximately $2,829 per family. The program does not have a waitlist.

Figure IV.10

Healthy Baby Healthy Child Program Characteristics		
National Evidence-Based Model	No	
National Model	No	
Communities Served (bold denotes communities that are among the top 18 most at risk)	**Boston**	
Client Demographics		
Race		
70.2% Black/African American	23.4% Hispanic/Latino	4%White
1.6% Asian	0.48% Native American	.32% Native Hawaiian/Islander
Age		
27.2% age 31-40	19.8% age 22-25	17.1% age 26-30
12% age 20-21	12.02% > 40	6.6% age 19
4.5% age 17-18	.78 % 15-16	
Educational Attainment		
32.25 grade 9-11	26.25% High School Graduate	23.50% Tech, Voc or Associate Degree
7.5% Grade 1-8	5.25% 4 yr college	2.75% GED
1.5% no formal school	1% Graduate school	
Health Insurance		
92% of clients have health insurance		

Healthy Families Massachusetts (HFM)

Healthy Families Massachusetts (HFM), based on Healthy Families America, is a comprehensive home visiting program that provides a broad range of services. Paraprofessionals provide voluntary program services to first time teen parents, less than age 20 years. Families are

eligible to enroll in services during the prenatal period and up to the child's first birthday, and they may receive home visiting until the child's third birthday. Program sites are located in 25 community-based agencies throughout Massachusetts and programs services include family centered assessments, child development screenings, groups, goal setting activities, and referrals to other community services. The goals of HFM are to prevent child abuse and neglect by supporting positive, effective parenting skills; achieve optimal health, growth, and development in infancy and early childhood; promote increased educational attainment, job, and life skills; reduce repeat teen pregnancies; and promote optimal parental health and wellness.
HFM currently receives 100% direct funding from state funds through the Massachusetts Children's Trust Fund (CTF).

For FY11, HFM programs will receive a total of $8.9M, with a maximum of $3,300 to be allocated per family. During FY10, HFM served approximately 3,131 teen mothers and fathers and 2,317 children. Currently, HFM programs are not permitted to carry waitlists for services; the program maintains capacity limits to ensure that caseloads do not exceed 20 families per home visitor. Whenever possible, families who are eligible, but not enrolled in HFM due to capacity limits, are referred to other services to meet their needs. Current funding only allows program services to reach approximately one-third of the target population each year.

Figure IV.11

Healthy Family Massachusetts Program Characteristics		
National Evidence-Based Model	Yes	
National Model	Yes	
Communities Served (bold denotes communities that are among the top 18 most at risk)	**Statewide as needed**	
Client Demographics		
Race		
32% Hispanic/Latino	30% White	11% Black
11% Blank	5% Multi-racial	3% Asian/ Pacific Islander
3% Unknown	2% Other	.2% Native American
Age		
21% age 19	20% age 18	19% age 17
13% age 20	13% age 16	8% age 15
3% age 1	1% age 13	2% age 21 & up
Sex		
96% Female (mothers)	4% Male (fathers)	
Health Insurance		
MassHealth (Medicaid) -61%	Unknown 27%	Private/Commercial 7%
Other, specify 2%	Healthy Start 1%	None =1%
CMSP 0.03%		

Parent-Child Home Program (PCHP)
The Parent-Child Home Program (PCHP) is an evidence-based national home visiting model that provides home-based literacy and parenting services through the PCHP curriculum. Paraprofessionals offer home visiting services to at-risk parents and children that are between the

ages of 18 months and 4 years. PCHP primarily serves low-income families and families that are at-risk due to limited parental education, homelessness, limited English and limited literacy, isolation, or those who are recent immigrants. The goal of the program is to prepare young children for school readiness and success by increasing language and literacy skills, enhancing social-emotional development, and strengthening the parent-child relationship. PCHP utilizes a non-didactic approach that promotes and models behaviors for parents that enhance children's literacy and development. Program services also assist socio-emotional development and make appropriate referrals as needed.

In FY09, 1,500 families were provided services throughout Massachusetts. PCHP receives 95% of its funding from the state Department of Early Education and Care (EEC) and the additional 5% from federal funds and other financial resources. It costs approximately $2,750 per family per program year. As of FY09, the statewide waiting list for PCHP consisted of approximately 400 families (with 18 of 30 sites reporting). According to program administrators, this number greatly underestimates the number of families that are eligible and who would like to be enrolled in PCHP. Due to fiscal constraints, most site coordinators do not continue to build waitlists or conduct active outreach once their annual caseload is filled.

Administrators also note that although the program seeks to enhance family social-emotional development, PCHP is not designed to serve children with serious developmental delays or parents who have serious mental health issues. Additionally, PCHP does not have the capacity to provide therapeutic intervention services. As a result, PCHP provides referrals to EI or other therapeutic services.

Figure IV.12

Parent-Child Home Program Characteristics		
National Evidence-Based Model	Yes	
National Model	Yes	
Communities Served (bold denotes communities that are among the top 18 most at risk)	Acushnet, Adams, Amesbury, Andover, Athol, Barre, Belchertown, Berkeley, Bolton, **Boston**, Bradford, Brookline, Cambridge, Cheshire, Clarksburg, Clinton, Dartmouth, Dighton, Fairhaven, Fitchburg, Florida, Framingham, Groveland, Hardwick, Haverhill, Hubbardston, Lakeville, Lancaster, Lanesboro, **Lawrence**, Leominster, **Lowell, Lynn**, Marlborough, Medford, Methuen, Monson, Needham, **New Bedford**, New Braintree, Newton, **North Adams**, Northampton, North Andover, Oakham, Orange, Palmer, Petersham, **Pittsfield**, Plymouth, Quincy, Rawley, Rehoboth, Royalston, Salem, Seekonk, Shirley, Somerville, South Hadley, **Springfield**, Sterling, Stow, Swansea, Taunton, Thorndike, Three Rivers, Turner's Falls, Waltham, Ward Hill, Ware, Wareham, Warren, Watertown, Wellesley, West Brookfield, Williamstown, and **Worcester**	
Client Demographics		
Race		
37% Hispanic/Latino	31% White	13% Other
10% Black	9% Asian	
Educational Attainment		**Marriage Type**
35% Non-High School Graduates		41% Single Parents

Federal or Other Assistance		
58% Receiving Medicaid	49% Receiving Food Stamps	48% Receiving Government Aid

Parenting Works

The Parenting Works program run by Square One, a community-based agency in Springfield, is a home visiting program that provides services to at-risk pregnant and postpartum women or men of any age and their children from birth through the age of 5 years. Eligibility for the program includes such indicators as lack of sustainable employment, domestic violence, homelessness, and substance abuse. The Parenting Works program receives 100% of their funding from private foundations. Program participants receive home visits from MSW interns or MA art therapy interns. Program services focus on providing parent education and support across the following areas: family income and employment parent skills, substance dependency, mental health issues, child program referrals, and a family support network. Service components include family and child assessments, emotional/mental health assessments, family service plans, and referrals as needed.

In FY09, Parenting Works served 15-20 at-risk families through home visiting and approximately 200 families in group-based sessions. Program administrators state that because the program is staffed by students, they face service delivery constraints during the summer months, even though they occasionally have summer interns.

Figure IV.13

Parenting Works Program Characteristics	
National Evidence-Based Model	No
National Model	No
Communities Served (bold denotes communities that are among the top 18 most at risk)	Chicopee, **Holyoke, Springfield**, West Springfield, and surrounding communities
Client Demographics	
Race	
72% families minority: primarily Hispanic & African American	
Marriage Type	
83% families single head of household	
Age	**Health Insurance Type**
Majority of families are in their 20's	Majority of families on MassHealth (Medicaid)

Parents as Teachers (PAT)

Parents as Teachers (PAT), a national evidence-based home visiting model, provides family-centered services that help to increase parent knowledge, promote optimal child development, and increase school readiness. PAT provides services to parents (75% of PAT programs have

universal access) along the continuum of pregnancy to kindergarten. Grounded in research, PAT developed the *Born to Learn* evidence-curriculum that supports and encourages school readiness and the improvement of child health. The *Born to Learn* curriculum includes a health assessment, annual developmental screen, and referrals to support parents in their role as teachers. The curriculum can also help to improve parenting practices, provide early detection of developmental delays and health issues including nutrition and wellness, prevent child abuse and neglect, and ensure children are ready to learn.

In FY09, PAT certified parent educators, across the four Massachusetts sites, provided services to 279 families and 328 children. Funding sources vary across the four program sites. In Attleboro, for example, the Massachusetts the Attleboro PAT/Family Center receives 80% of its funding from EEC and 20% from non-profit sources. Two of the four programs report waitlists, with 17 families currently waiting for services. Although the Attleboro PAT program noted that they do not currently have a waiting list, at times they have had up to 15 families waiting for services. One significant limitation of the PAT program, noted by the Attleboro PAT, is the lack of PAT parent educators (home visitors) who speak a second language.

Figure IV.14

Parents as Teachers Program Characteristics		
National Evidence-Based Model	Yes	
National Model	Yes	
Communities Served (bold denotes communities that are among the top 18 most at risk)	Attleboro, Milford, **New Bedford**, and **Pittsfield**	
Client Demographics		
Child Race		
59.7% (European-American)	12.9% Hispanic / Latino	10.1% Unknown
6.0% Asian	5.5% African American	3.0% White (Non-European origin)
2.2% Multi-Racial	0.5% Other	0.0% American-Indian
0.0% Native Hawaiian or Pac. Islander		
Language/Foreign Born		
11% of PAT families spoke Spanish as their primary language		
18.3% of all families had at least one parent who was foreign born		
Top 5 Family Characteristics		
22% Low Income	20% Limited English Proficiency	16% Low Educational Attainment
13% Single Parent Household	11% Child with Disabilities	
Military Families		
0% of families are active duty military		

Visiting Moms
Visiting Moms is a home visiting program that serves pregnant and postpartum women of any age. Operated by the community-based JFCS organization, the program provides support and nurturance to pregnant and parenting mothers during their baby's first year. Home visitors – who

are volunteers from the community – provide on-going assessment of psychological, economic, housing, health, and infant development with the support of clinical supervisors. In addition, group services, support groups, and referrals to additional services are also provided on an as-needed basis. While there is no formal educational requirement for home visitors, the majority of home visitors have a Bachelor's degree, some with advanced degrees.

In FY09, services were provided to 190 mothers residing in the service catchment area. Visiting Moms received 80% of its funding from private philanthropic organizations, and the additional 20% from JFCS support. Although the program is adequately meeting the needs of English-speaking families, there are currently gaps in capacity for Spanish-speaking families. In addition, although Visiting Moms operates throughout the year, there are geographical limitations based upon the location of home visitors.

Figure IV.15

Visiting Moms Characteristics		
National Evidence-Based Model	No	
National Model	No	
Communities Served (bold denotes communities that are among the top 18 most at risk)	**Boston**, Cambridge**, Malden, Somerville**, Waltham, and the surrounding 40 communities	
Client Demographics		
Race		
70% White	11% Hispanic / Latino	7% African American
6% Asian	6% Multi-racial or Other	

Young Parents Support Program (YPSP)
The Massachusetts Department of Children and Families (DCF) administers the Young Parents Support Program (YPSP) across 27 statewide program sites. The YPSP is a home visiting program serving young parents up to the age of 23 with the goal of improving outcomes and mitigating the adverse consequences of early childbearing. The target population includes hard to reach, isolated young parents with mental health, trauma, and homelessness issues who are not involved and/or not eligible for other types of young parents services. Typically, services for individuals and families include home visiting, outreach, case management, mentoring, and parenting groups. Services focus on parenting skills education, household management, budget training, education and job planning, advocacy referral for medical care, housing, child care, and adoption counseling. The program encourages the use of the Power Source Parenting Curriculum developed by the Lionheart Foundation.

Each program site determines the necessary qualifications for their home visitors. One example is seen at the YPSP program run by Massachusetts Catholic Charities North, where YPSP home visitors constitute a multi-disciplinary team consisting of social workers (MSW, BSW), MSW interns, and bi-lingual paraprofessionals.

The YPSP received 100% state funding in FY10 and with it was able to serve 1,122 young parents. Although waitlists vary depending on the program site, in FY10, there were a total of 213 families on the waitlist. Overall program administrators note that capacity is the biggest

program concern, as the annual maximum program obligation for each site limits the ability of the program to meet the demand of qualified families who are eligible and waiting for services.

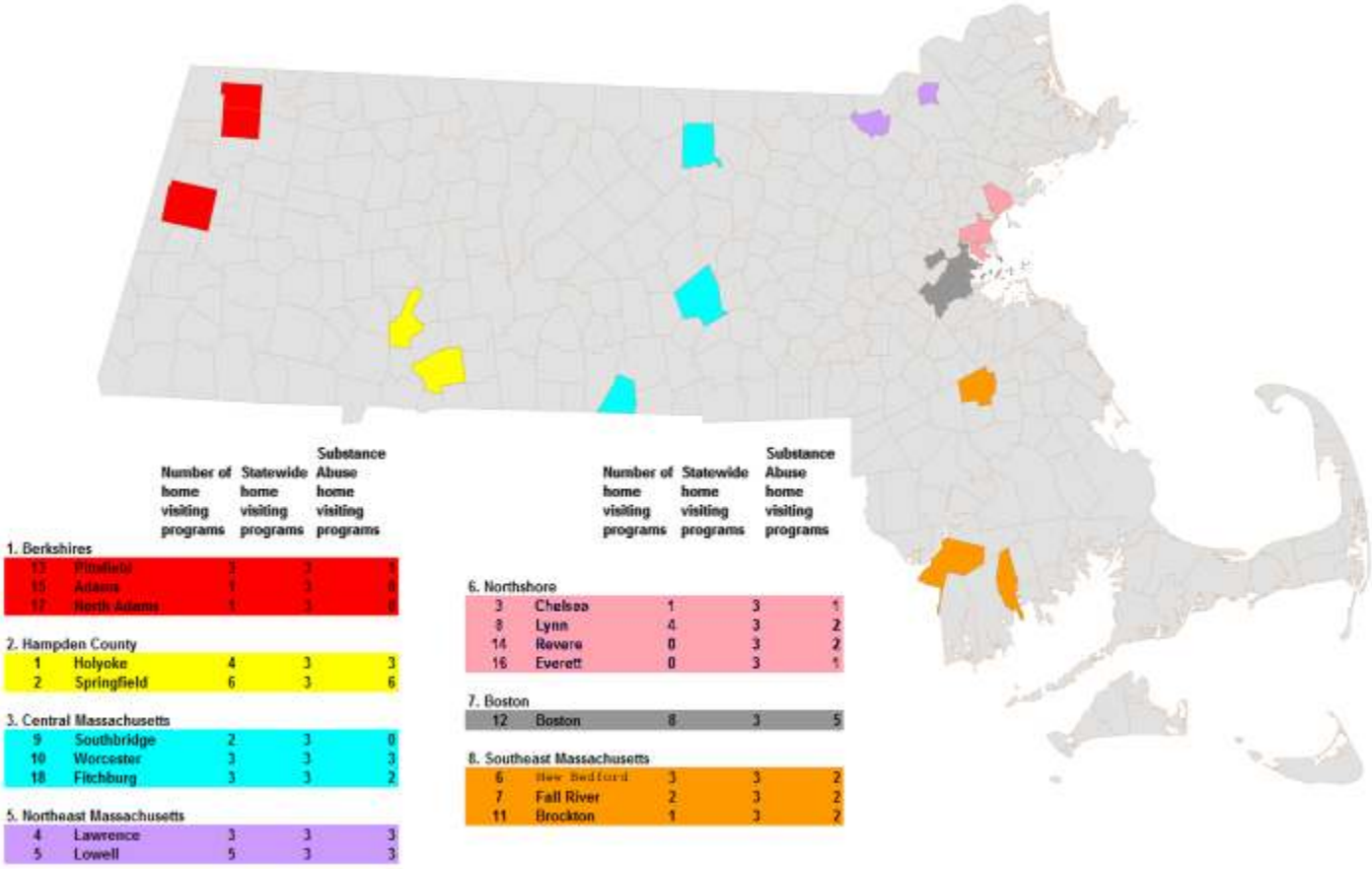
Figure IV.16

Young Parents Support Program Characteristics		
National Evidence-Based Model	No	
National Model	No	
Communities Served (bold denotes communities that are among the top 18 most at risk)	Beverly, **Boston (Jamaica Plain), Brockton,** Cambridge, **Chelsea,** Danvers, Falmouth, **Fitchburg,** Gloucester, **Greater Lynn**, **Holyoke,** Ipswich, Lynnfield, Manchester by the Sea, **Lawrence, Lowell,** Marblehead, **New Bedford,** Rockport, Oxford, **Pittsfield**, Saugus, Salem, **Springfield**, Taunton, West Newton, and **Worcester**	
Client Demographics		
Race/ Ethnicity		
44.1% Hispanic/Other Hispanic/Puerto Rican	27.7% Caucasian/European	12.7% Black/ African American/ Haitian Creole
8.3% Multi-Racial/ Cape Verdean	3.5% Asian/Islands/Pacific	3.2% Other
0.3% Portuguese	0.2% Native American	
Age		
62% age 19-23	35.4% age 16-18	2.1% age 13-15
0.3% age 12		
Sex		
87.4% Female	12.6% Male	
Top 5 Services Received		
25.9% Life Skills Education	15.2% Job/Vocational Training	14.9% Attended GED Program
12.8% Job Search/Referral	9.3% Attended High School	

Capacity Map

The map below charts the service locations of the aforementioned home visiting programs by the top 18 at-risk communities in Massachusetts. Notably, many of the communities identified as most at-risk in the state have limited access to maternal, infant, and early childhood home visiting programs. The communities of the North Shore, directly north of Boston, and many of the western rural communities, in particular, significantly lack home visiting services. These communities are of considerable concern, as they experience high levels of poverty and increasing rates of immigrants, two indicators of adverse health outcomes that require additional supports and services.

Figure IV.17 Home Visiting Capacity Map



		Number of home visiting programs	Statewide home visiting programs	Substance Abuse home visiting programs
1. Berkshires				
13	Pittsfield	2	3	1
15	Adams	1	3	0
17	North Adams	1	3	0
2. Hampden County				
1	Holyoke	4	3	3
2	Springfield	6	3	6
3. Central Massachusetts				
9	Southbridge	2	3	0
10	Worcester	3	3	3
18	Fitchburg	3	3	2
5. Northeast Massachusetts				
4	Lawrence	3	3	3
5	Lowell	5	3	3

		Number of home visiting programs	Statewide home visiting programs	Substance Abuse home visiting programs
6. Northshore				
3	Chelsea	1	3	1
8	Lynn	4	3	2
14	Revere	0	3	2
16	Everett	0	3	1
7. Boston				
12	Boston	8	3	5
8. Southeast Massachusetts				
6	New Bedford	3	3	2
7	Fall River	2	3	2
11	Brockton	1	3	2

Individual Program Capacity and Statewide Gaps

Massachusetts has a solid foundation of home visiting programs and home-based assets. The home visiting programs in the state are tailored to address high risk populations, such as homeless families, families experiencing domestic violence and substance abuse, and parenting teens. The state's home visiting programs also address high risk issues, such as children with special health care needs, family literacy, school readiness, economic self sufficiency, maternal depression, and child development. However, despite this foundation, Massachusetts home visiting programs are not meeting the needs of all eligible families, as there are significant gaps in maternal, infant, and early childhood home visiting in Massachusetts.

The following sections address capacity issues. The first section focuses on the capacity of individual home visiting programs to meet the needs of eligible families. The proceeding section highlights maternal, infant, and early childhood home visiting service gaps as identified by Home Visiting Program Survey respondents. Both sections also use available data from the following partner agencies and offices to provide a comprehensive overviews of programmatic limitations and statewide gaps: 1) Title II CAPTA inventory and current community-based and prevention-focused programs, 2) Head Start/ Early Head Start community-wide strategic plan/needs assessment, and 3) Massachusetts Domestic Violence Coalition needs assessment and STOP Violence Against Women statewide plan. Collectively, this information is used to inform the statewide understanding of home visiting capacity and known gaps in Massachusetts' highest risk communities.

Individual Program Capacity
As outlined in the home visiting program profiles, current Massachusetts programs are reaching very high risk families and populations through intensive outreach and home-based (as well as group-based) case management services. Despite these efforts, Massachusetts home visiting programs are not able to enroll all eligible families and are not operating in all high risk communities. In addition, due to fiscal constraints, many other programs have had to tighten eligibility requirements, which ultimately excludes otherwise eligible families and in turn creates significant service gaps. Many families who qualify for services are either waitlisted, do not have a program operating in there area that meets their needs, or are left out due to restrictive eligibility requirements. The following table outlines, for each home visiting program: 1) the current waitlist for eligible families, and 2) programmatic delivery of socio-economic, developmental, and health-related services.

Figure IV.18 Home Visiting Service Components and Capacity

Program Name	Waitlist	Premature Birth	LBW Infants	Infant Mortality	Poverty	Crime	Domestic Violence	School Drop Out	Substance Abuse	Unemployment	Child Maltreatment	Maternal Depression	Child Development	School Readiness
Boston Healthy Start Initiative	None	✓	✓	✓	✓	✓	✓	No	✓	✓	✓	✓	✓	No
Boston Home Visiting Collaborative	None	No	No	No	No	No	No	No	No	No	No	✓	No	No
Early Connections	None	No	No	No	No	No	No	No	No	No	No	✓	✓	No
Early Head Start	4,000*	✓	✓	✓	✓	No	✓	✓	✓	No	✓	✓	✓	✓
Early Intervention	None	✓	✓	No	No	No	No	No	No	No	No	No	✓	✓
Early Intervention Partnership Program	None	✓	✓	✓	✓	No	✓	No	✓	✓	✓	✓	✓	No
F.O.R Families	None	No	No	No	✓	No	✓	No	✓	✓	✓	✓	✓	No
Good Start	71	✓	✓	✓	No	No	No	No	No	No	✓	No	✓	No
Healthy Baby Healthy Child	None	✓	✓	✓	✓	No	✓	No	✓	✓	✓	✓	✓	No
Healthy Families Massachusetts	2,098 families eligible for HFM but were not able to be served due to capacity limits	✓	✓	✓	✓	No	✓	✓	✓	✓	✓	✓	✓	✓
Parent Child Home Program	400	No	No	No	No	No	No	No	No	No	No	✓	✓	✓
Parenting Works	None	No	No	No	✓	No	✓	No	✓	No	No	✓	✓	No
Parents as Teachers	17	✓	✓	✓	No	No	No	No	No	No	✓	No	✓	✓

Program Name	Waitlist	Premature Birth	LBW Infants	Infant Mortality	Poverty	Crime	Domestic Violence	School Drop Out	Substance Abuse	Unemployment	Child Maltreatment	Maternal Depression	Child Development	School Readiness
Visiting Moms	None	✓	✓	✓	✓	No	✓	No	✓	✓	No	✓	✓	No
Young Parents Support Program (YPSP)	213	No	No	No	✓	✓	✓	✓	✓	✓	✓	No	✓	No

* includes HS/EHS waitlist numbers

Statewide Gaps

Data derived from survey respondents, state agency needs assessments, and partner agencies' statewide plans highlights significant programmatic gaps in maternal, infant, and early childhood home visiting across the state. The following information, outlined thematically, highlights Massachusetts' gaps.

Themes

- Maternal Mental Health: Massachusetts home visiting programs consistently noted the need to increase services for women in the postpartum period. Programs specifically noted the following areas of concern:
  - Postpartum/Maternal depression
  - Lack of mental health clinicians/Long waiting lists

- Immigrants: Massachusetts home visiting programs consistently noted the need to increase services for immigrants, particularly:
  - New immigrants, because they are not eligible for entitlements until after 5 years of residence in the US. Immigrant families can, however, access EHS immediately, as social security numbers are not required for enrollment.
  - Immigrant populations typically lack services and resources in their native languages
  - Immigrant populations are also less likely to report domestic or sexual violence
  - Particularly at risk immigrant populations include Somalians, Cape Verdeans and Haitians

- Family Economic Self-Sufficiency: Massachusetts home visiting programs consistently noted the need to bolster economic self sufficiency programming and homeless services:
  - Target families in shelters and motels
  - Housing resources to include financial assistance with deposits and arrearages (e.g. increasing rent and foreclosure rates have impacted target populations that consistently relocate)
  - Financial literacy
  - Workforce development, including career services
  - Food security

- Transportation

- Child Health and Development: Massachusetts home visiting programs consistently noted the need to increase services for healthy infant growth and child development. Specific areas of concern included:
  - Closing the achievement gap
  - Healthy development of premature infants
  - Infant and early childhood mental health
  - Enhanced screening and treatment for children with special health care needs, including speech/language, OT/PT, sensory and learning disabilities, and autism
  - Family nutrition literacy
  - Family literacy and parent education

- Family Violence/Trauma: Massachusetts home visiting programs consistently noted the need to increase services for families experiencing trauma and/or family violence, particularly:
  - Domestic violence, including intimate partner violence (IPV)
  - Child risk prevention, including child maltreatment (CM)
  - Shortage of shelters to meet needs of families experiencing DV/IPV
  - Trauma experienced by families, especially refugees or US military families

- Comprehensive System of Care: Massachusetts home visiting programs expressed concern about the need to increase collaborations within family support programs to connect home visiting programs, center-based programs, and other family support programs into a seamless structure of family services. Programs also noted the increased need for:
  - A comprehensive approach to data collection and data sharing in order to avoid duplication of services, and to provide clear and consistent information
  - Allied health professionals (e.g. physical therapists, speech therapists, and occupational therapists)
  - Primary care, dental care and the medical home model
  - Clinicians of color and/or multi-lingual, multi-cultural workforce who are highly trained and have the competencies to provide home visiting services in at-risk communities
  - Fiscal resources to provide on-going trainings for home visitors
  - Continuity of care for transition populations, such as teens and adolescents or families with complex needs
  - Fiscal resources to address client retention
  - Program evaluation

- Non-Traditional Populations: Massachusetts home visiting programs consistently noted the need to increase services to non-traditional populations who typically are not targeted for services in the parent, infant, and early childhood spectrum. Other caregivers for young children have increased and need home visiting support:
  - Fathers
  - Grandparents who are parenting
  - Individuals with non-felony Criminal Offender Record Information (CORIs)

- Top 18 At-Risk Communities: Among Massachusetts' top 18 at-risk communities, the following communities lack important maternal, infant, and early childhood home visiting services:

Figure IV.19

Early Head Start				
Unmet Needs by City/Town (identified at-risk city/towns without an EHS home visiting program):				
Adams	Brockton	Chelsea	Everett	Fitchburg
Lawrence	New Bedford	North Adams	Pittsfield	Revere
Worcester				

Figure IV.20

Healthy Families Massachusetts (HFM)			
% of target population (first time parents under age 21) *NOT receiving services in top 18 at risk city/towns:			
Adams: 69 %	Boston: 81%	Brockton: 57%	Chelsea: 77%
Everett: 82%	Fall River: 82%	Fitchburg: 66%	Holyoke: 87%
Lawrence: 67%	Lowell: 74%	Lynn: 83%	New Bedford: 71%
North Adams: 41%	Pittsfield: 75%	Revere: 75%	Southbridge: 83%
Springfield: 66%	Worcester: 81%		

* The HFM program model assumes a 90% acceptance rate for the target population, i.e. that only 90% of families eligible for and offered HFM will accept services.

Figure IV.21

Sexual Assault and Domestic Violence Shelters/Programs				
Unmet Needs by City/Town (top 18 at risk city/towns without a DV program):				
Adams	Chelsea	Everett	North Adams	Revere
Southbridge				

Figure IV.22

Substance Abuse		
Unmet Needs by City/Town (top 18 at risk city/towns without a substance abuse home visiting program):		
Adams	North Adams	Southbridge

[1] Olds, D.L., Henderson, C.R., Chamberlain, R., and Tatelbaum, R. (1986). Preventing child abuse and neglect: A randomized trials of nurse home visitation. Pediatrics; 78; pp 65-78.
[2] Ibid.
[3] Pew Center for the States. http://www.pewcenteronthestates.org/. Accessed: August 6, 2010.